RESET / CLEAR FORM

PARAMOUNT
LIFE & GENERAL
INSURANCE

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ACCIDENTAL INDEMNITY FORM 1

CERTIFICATE OF CLAIMANT

Policyholder/Creditor : _____ **Claim:** _____

Master Policy No : _____ **Policy/Certificate No :** _____

GENERAL DATA OF CLAIMANT

1. **Full Name :** _____

If claimant is a married woman, state maiden name : _____

Date of Birth : _____

Source from which the date of birth was obtained (Specify if birth/baptismal certificate of local civil registrar) :

_____

_____

Residence Address : _____

Business Address : _____

2. **Occupation at the date of accident :** _____

Name and address of employer : _____

Date claimant last attended his usual occupation : _____

DATA OF ACCIDENT

3. **Date of Accident :** _____ **Time of Accident :** _____ ☐ **AM** | ☐ **PM**

Place of Accident: _____

How did it occur : _____

Did the accident occur during the performance of the occupation? ☐ **YES** | ☐ **NO** **If yes, describe details**

_____

_____

What was the nature of claimant's occupation immediately prior to the accident? _____

_____

4. **Describe in detail the nature and extent of the injuries. If arm, leg or eye, state whether right or left :** _____

_____

_____

QUESTIONS FOR VEHICULAR ACCIDENT ONLY

5. **Were you a passenger in a public conveyance at the time of accident?** ☐ **YES** | ☐ **NO** **If yes, state the type of conveyance and the plate number :** _____

If yes, describe briefly : _____

Was said conveyance then on a scheduled passenger service and on an established regular route? _____

_____

(PLEASE ATTACH A TRAFFIC POLICE INVESTIGATION REPORT RELATIVE THERETO)

6. **Names and addresses of all physicians who attended you for the injuries sustained and period of treatment.**

Name of Physician	Address	Inclusive Date of Attendance	Nature of Injuries

Who of the physicians named #6 has been in regular medical attendance during your confinement/ treatment?

_____

- CONTINUATION AT THE BACK -

7. Names and addresses of hospital, clinic or other institution where you had been confined and received treatment (attach a certified true copy of clinical records of hospital).

Name of Physician	Address	Inclusive Date of Attendance	Nature of Injuries

8. Are you still confined by doctor's order? ☐ **YES** | ☐ **NO**

If yes, please check if confined to: ☐ **HOSPITAL** | ☐ **HOUSE**

State the period you expect to be necessarily and entirely confined to hospital/house by doctor's order.

From : _____ **To :** _____

Did you perform or do you expect to perform any part of your business or work during the above period?

☐ **YES** | ☐ **NO** **If yes, state what :** _____

_____

9. If no longer confined to hospital/house but still receiving treatment, state the following :

a. What treatment you are receiving? _____

b. By whom? _____ **Where?** _____

10. Indicate your present condition as you understand it and describe the remaining effects, if any, from your accidental injury:

Please check :	PRESENT CONDITION	REMAINING EFFECTS
a. ☐ I am at present fully recovered :		
b. ☐ I am partially disabled (able to do some work) :		
c. ☐ I am totally disabled (unable to attend to any duties) :		

11. If you checked either question 10a or 10b, state :

a. When you returned to work (If an employee, please attach employer's confirmation letter).

_____

b. Why you have not yet returned to work? _____

FRAUD WARNING

"Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim."

DATA PRIVACY CONSENT STATEMENTS

I hereby consent to the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, storage, and disclosure to third parties, by Paramount Life & General Insurance Corporation (hereafter, "PLGIC"), its subsidiaries, affiliates, directors, officers, employees, and agents (a) to verify and/or confirm any information provided or representation made, (b) to provide, facilitate, monitor and improve the quality of services offered or may be offered by PLGIC, (c) for customer/client profiling, and (d) for marketing purposes. I likewise consent to the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, and storage by authorized third parties for the foregoing purposes.

Such processing may be conducted for the duration of my availment of PLGIC's products, services, facilities and/or channels. I further consent that the personal data stated above shall be retained by PLGIC for an additional period of at least five (5) years, or for a longer period if the personal data is related to or required to be preserved for litigation or to comply with legal or regulatory requirement. I likewise consent to the correction, amendment, deletion and/or disposal by PLGIC, its subsidiaries, affiliates, directors, officers, employees, agents, and authorized third parties, of the personal data which may be inaccurate or incorrect.

I understand and agree that the consent hereby given may be revoked or withdrawn through formal written notice to PLGIC.

Signed at _____ this _____ day of _____ ,20 _____

Witness' Name (In print) _____

Signature _____

Occupation _____

Address _____

_____

Signature of Claimant

If Insured cannot sign this form, it should be signed by a near relative or any other responsible person in-charged of the Insured during his/her disability